

Facial Spectrum, Inc.
PATIENT REGISTRATION

Date: _____

(Mr., Mrs., Ms., Dr.) First Name _____ M.I. _____ Last Name _____ Nickname _____
Sex: Male Female Date of Birth _____ Age _____ Soc Sec. # _____ Email _____
Street _____ City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____ Work Phone _____
Dentist/City/State _____ Physician/Practice Name _____
Driver's License # _____ Emergency contact _____ Relation: _____ Phone _____
If going under anesthesia, please list driver/caretaker: _____ Relation: _____ Phone _____
Who referred you to this office? _____ Have you ever been a patient in our office? Yes No When? _____
Who is responsible for your account? Self Spouse Father Mother Other _____ Advanced Directive? Yes No
Name _____ Date of Birth _____ Soc Sec # _____ Phone _____
 Same address as above Street _____ City _____ State _____ Zip Code _____
Employer Name _____ Phone _____

INSURANCE INFORMATION

**The patient (or parent, if minor child) is responsible for all fees, regardless of insurance coverage.
(It is Patient/Guarantor Responsibility to fill out ALL insurance information)

Patient: Student: Full Time Part Time Not School Name/City/State _____
Married: Married Divorced Separated Widow Single
Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO? _____

Primary Dental Insurance

Employer _____
Ins. Name _____ **Plan** _____
Street _____
City/St/Zip _____ Phone _____
Policy Holder _____ **Relation** _____
Date of Birth _____ **SS#** _____
ID Number _____
Group # _____ **Group Name** _____

Primary Medical Insurance

Employer _____
Ins. Name _____ **Plan** _____
Street _____
City/St/Zip _____ Phone _____
Policy Holder _____ **Relation** _____
Date of Birth _____ **SS#** _____
ID Number _____
Group # _____ **Group Name** _____

Secondary Dental Insurance

Employer _____
Ins. Name _____ **Plan** _____
Street _____
City/St/Zip _____ Phone _____
Policy Holder _____ **Relation** _____
Date of Birth _____ **SS#** _____
ID Number _____
Group # _____ **Group Name** _____

Secondary Medical Insurance

Employer _____
Ins. Name _____ **Plan** _____
Street _____
City/St/Zip _____ Phone _____
Policy Holder _____ **Relation** _____
Date of Birth _____ **SS#** _____
ID Number _____
Group # _____ **Group Name** _____

All professional services provided are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient (or parent, if minor child) is responsible for all fees, regardless of insurance coverage. It is expected that all fees will be paid at the time of services unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION / FINANCIAL RESPONSIBILITY

I authorize the release of any medical/dental information necessary to process my insurance claim. I also request payment of government/private insurance benefits to the doctor. I understand that I am responsible for my total bill, including any portion of those charges not covered by my insurance plan. I also agree that I am responsible for all billing collection charges for any overdue or unpaid account.

Date _____ **Signature (Patient)** _____ **Guarantor** _____

(If patient is a minor, parent or legal guardian must sign)